PATIENT REGISTRATION FOR

Please Print

Last Name: _____ Home Phone: _____

First Name: _____ M.I. ____ Work Phone: _____

Street Address: _____ Cell Phone: _____

City _____ State ____ Date of Birth: _____

Zip Code: _____ Sex _____ Social Security #: _____

Marital Status: _____ Driver's License #: _____

Employed: Yes / No *(Please circle one)* Referred By: _____

Employer: _____

Occupation: _____

Employer Address: _____

Spouse's Name: _____ Employed By: _____

Employer Address: _____ Work Phone: _____

Nearest Friend or Relative In Case of Emergency: _____

Phone: _____ Relationship to Patient: _____

I Will Be Paying Today By: _____ CASH _____ CHECK _____ CHARGE _____

Email: _____

Is it OK to leave message to confirm appointment? ☐ YES ☐ NO

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Address: _____ Address: _____

City: _____ City: _____

State: _____ Zip: _____ State: _____ Zip: _____

Phone: _____ Phone: _____

Insured's Name: _____ Insured's Name: _____

Insured's ID #: _____ Insured's ID #: _____

Insured's Date of Birth: _____ Insured's Date of Birth: _____

Group Name or #: _____ Group Name or #: _____

Relationship to Patient to Insured: _____ Employer Plan: ☐ YES ☐ NO

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services. I hereby authorize the doctor to administer any treatment as he may deem advisable in the diagnosis and treatment of this patient. I also authorize any physician, hospital, or clinic to provide full details of my medical history and treatment to this office and I agree that photocopies of this form will be as valid as the original. I understand that I have the opportunity to review and ask questions about the financial and privacy policies of the office.

I hereby authorize payment to the provider of care. I understand that I am financially responsible for all charges not covered by this assignment (including my annual deductible and/or co-payment) at the time of service. I also agree to pay any additional charges for collection fees, if I fail to promptly pay for services:

SIGNATURE: _____ DATE: _____

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, and most major credit cards. If we are listed as a provider in your PPO provider directory, we will need to see your insurance card each time you come into the office. **PAYMENT OF CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICES ARE DUE AT THE TIME OF VISIT**. If any charges are applied to your insurance deductible that you have not paid for in advance, we will call you with the amount due. This is due immediately. **NO PAYMENT ARRANGEMENTS WILL BE MADE FOR DEDUCTIBLES**. We charge $10 each time your co-payment is not paid on the date of service. You may leave your credit card number to avoid the call.

We charge a $40 fee for returned checks. The full amount of the check plus the service charge must be paid within 3 working days to avoid further action. Balances older than 30 days will be charged late fees of $10 per month. Charges may also be made for appointments cancelled without 24 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company.
2. Not all services are a covered benefit in all contracts. Some insurances arbitrarily select certain services they will not cover. You will be responsible for any non-covered services.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. We realize that temporary financial problems may affect the timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If we do not hear from you, it is our policy to refer your account to an outside collection agency.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, **PLEASE** don't hesitate to ask us. We are here to help you.

Please sign and date this paper to demonstrate that you have read and understand our financial policy:

SIGNED _____ DATE: _____

I hereby acknowledge that I have had the opportunity to review and ask questions about Dr. Bonilla's financial and privacy policies.

NAME _____ DATE: _____

R. MAURICE BONILLA, M.D.
905 W. PLATT ST
TAMPA, FLORIDA 33606
(813) 254-0222

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OF INTERNAL MEDICINE

DIPLOMATE,
GERIATRIC MEDICINE

WAIVER

I HEREBY UNDERSTAND THAT THERE ARE TIMES WHEN MY INSURANCE COMPANY WILL NOT PAY FOR ROUTINE TESTS SUCH AS EKG, SPIROMETRY, OR BLOOD TESTS. I AGREE TO PAY FOR ANY TESTS DEEMED NECESSARY BY THE DOCTOR BUT NOT REIMBURSED BY MY INSURANCE COMPANY.

SIGNED _____ DATE _____

PLEASE PLACE BOTH SIDES OF INSURANCE CARD HERE:

R. MAURICE BONILLA, M.D., P.A.
905 W. PLATT ST.
TAMPA, FLORIDA 33606
(813)254-0222
www.doctorbonilla.com

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AMERICAN BOARD OF
BARIATRIC MEDICINE

Maurice Bonilla M.D., P.A. Notice of Privacy Practices

This notice describes how your health information may be used and disclosed, and how you can access this information.

We are required to keep your health information secure and confidential, by law. Also, by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment information or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff may enter your treatment information into our computer system.

We may share your medical information with our business associates. We use a written contract with each associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or emails or we may call you to remind you of your appointment. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law.

If this practice is sold, your information will become the property of the new owner.

We will need to release some or all of your health information, when required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we do not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the normal uses.

You have the right to receive communication about your health information in the manner you prefer.

You have the right to transfer a copy of your health insurance information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. You must allow a reasonable amount of time, (such as two weeks), for us to copy your records.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose information to. If our privacy and security measures or systems are breached, we will notify you.

You have the right to receive a copy of this notice. If we change the details of this notice, we will notify you in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Ave., S.W. Room 509 F, Washington, D.C. 20201) or by email (OCRComplaint@hhs.gov.) You will not be retaliated against for filing a complaint.

Please contact our Privacy Officer, Carol Poris, at 813-254-0222 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

ACKNOWLEDGEMENT: I have received a copy of the R. Maurice Bonilla, M.D., P.A. Notice of Privacy Practices.

DATE: _____ SIGNED_____

R. MAURICE BONILLA, M.D., P.A.
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Patient Consent to receive Mail, Email, and Phone messages

Last Name_____ First Name_____M___

Do we have your permission to:

Leave appointment, billing, or treatment info on voicemail Y____ N_____

I give permission to share appointment, billing or treatment information with the person(s) listed: _____

_____

Signature of Patient_____ Date_____